cascade
CANOE&KAYAK
centers, inc.
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YOUTH MEDICAL TREATMENT AUTHORIZATION AND HISTORY

Name of Participant _____ Age _____

In the case of accident or illness, I hereby give permission that my child may be given emergency treatment. I understand that Cascade Canoe & Kayak Centers, Inc., the City of Bellevue, and their officers, employees, agents, servants and assigns assume no liability or financial obligation with respect to such rendering of services.

In the event that I, or the designated alternate, cannot be contacted, I further authorize and consent to the administration of any and all medical, dental, and surgical examinations or operations and treatment or all related care, including the administration of drugs, tests, anesthesia and/or blood transfusions, to the above named minor which may be ordered by the physician and/or dentist in attendance at the medical center deemed necessary for emergency treatment. I hereby consent to the release of any medical report(s) to any doctor or agency and consent to the admission of the above named minor to the hospital.

PERSONAL INFORMATION

Signature of Parent/Guardian _____ Date _____

Printed Name _____ Relationship _____

Primary person to contact in an emergency:

Name _____

Phone (day) _____ (eve) _____

Alternate person to contact in an emergency:

Name _____

Phone (day) _____ (eve) _____

Physician

Name _____ Phone _____

Address _____

Health Insurance Co. _____

Policy No. _____

MEDICAL HISTORY

Allergies _____

Medications _____

Limitations on activities: _____

Medical concerns (that we should be aware of) _____

_____

Date of Last Physical _____